



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645

(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Jerald Kelly, D.C.

Respondent Name

Zurich American Insurance Company

MFDR Tracking Number

M4-17-0270-01

Carrier's Austin Representative

Box Number 19

MFDR Date Received

October 3, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: " 99456 W5 WP MMI = 350.00
Shoulder IR w/ ROM = 300.00
Thoracic IR = 150.00
Nerve IR = 150.00
Total Paid = 800.00
Balance Due = 150.00"

Amount in Dispute: \$150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Submitted documentation does not include a response from the respondent. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 31, 2015	Designated Doctor Examination	\$150.00	\$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services from March 1, 2008 until September 1, 2016.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - P12 – Workers' compensation jurisdictional fee schedule adjustment.

- 309 – The charge for this procedure exceeds the fee schedule allowance.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Did the workers' compensation carrier respond to the medical fee dispute?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The Austin carrier representative for Zurich American Insurance Company is Flahive, Ogden and Latson. Flahive, Ogden and Latson acknowledged receipt of the copy of this medical fee dispute on October 11, 2016.

28 Texas Administrative Code §133.307 states, in relevant part:

- (d) Responses. Responses to a request for MFDR shall be legible and submitted to the division and to the requestor in the form and manner prescribed by the division.
 - (1) Timeliness. The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile **within 14 calendar days after the date the respondent received the copy of the requestor's dispute** [emphasis added]. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

Review of the documentation finds that no response has been received from Flahive, Ogden and Latson to date. The Division concludes that the carrier failed to respond within the timeframe required by §133.307(d)(1). For that reason the Division will base its decision on the information available.

2. Jerald Kelly, D.C. is seeking additional reimbursement for a Designated Doctor Examination which includes maximum medical improvement and impairment rating of three body areas. Per 28 Texas Administrative Code §134.204(j)(3), "The following applies for billing and reimbursement of an MMI evaluation... (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be \$350." The submitted documentation supports that Dr. Kelly performed an evaluation of Maximum Medical Improvement.

28 Texas Administrative Code §134.204(j)(4) states:

- (C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
 - (i) Musculoskeletal body areas are defined as follows:
 - (I) spine and pelvis;
 - (II) upper extremities and hands; and,
 - (III) lower extremities (including feet).
 - (ii) The MAR for musculoskeletal body areas shall be as follows.
 - (I) \$150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
 - (II) If full physical evaluation, with range of motion, is performed:
 - (-a-) \$300 for the first musculoskeletal body area; and
 - (-b-) \$150 for each additional musculoskeletal body area.
- (D) ...
 - (i) Non-musculoskeletal body areas are defined as follows:
 - (I) body systems;
 - (II) body structures (including skin); and,
 - (III) mental and behavioral disorders.
 - (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides...
 - (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be \$150.

Review of the submitted documentation finds that Dr. Kelly performed impairment rating evaluations of a right shoulder sprain/strain, SLAP tear/supra labral tear of the right shoulder, thoracic outlet syndrome, and vein compression. The MAR is calculated as follows:

Examination	AMA Chapter	§134.204 Category	Reimbursement Amount
Maximum Medical Improvement			\$350.00
IR: Right Shoulder (ROM)	Musculoskeletal System	Upper Extremities	\$300.00
IR: SLAP Tear (ROM)			
IR: Thoracic Outlet Syndrome	Nervous System	Body Systems	\$150.00
IR: Vein Compression	Vascular System	Body Systems	\$150.00
Total MMI			\$350.00
Total IR			\$600.00
Total Exam			\$950.00

3. The total MAR for the disputed services is \$950.00. Zurich American Insurance Company paid \$800.00. An additional reimbursement of \$150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$150.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	<u>Laurie Garnes</u>	<u>December 9, 2016</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.